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White Gates Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 3 December 2018 and was unannounced.

White Gates is a nursing home that is registered to provide accommodation and personal care for up to 51 people. At the time of our inspection there were 42 people living at the service, a number of whom were living with dementia.

At our last inspection we rated the service as good. At this inspection we found the evidence continued to support the rating of good and we did not identify, from our visit or ongoing monitoring, any serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People and their relatives told us they thought the service was safe. People's risks were identified and staff acted to address any known risks. People's medicines were stored and administered safely and infection control practices were followed. Staff understood how to protect people from harm and knew when to report any abuse.

Staffing levels were seen to be safe on the day, however we received feedback about people having to wait for care on some occasions. We have made a recommendation.

Appropriate recruitment checks were carried out to ensure staff were suitable to support people in the home. Staff received a comprehensive induction and ongoing training so that they could meet the needs of people who lived at the home.

People were supported to maintain good health and they had access to relevant healthcare professionals when they needed them. People benefitted from the way the staff worked with other services to ensure effective care and support. People had a varied and balanced diet to support their nutrition and health.

People's consent was sought in line with the legal requirements of the Mental Capacity Act. Where people's liberty was restricted to keep them safe, the provider had followed the requirements of the Act, and the Deprivation of Liberty Safeguards (DoLS), to ensure the person's rights were protected.

People were looked after by kind and caring staff who knew them well. People's privacy and independence was promoted. Contact with families and friends was encouraged. We received positive feedback from people and their families about the service provided.

People were supported to make decisions about their day to day care, including taking part in any activities and with their meals. People were given opportunities to go on occasional outings.

Care for people at the end of their life was proactive and responsive. The service followed nationally

recognised standards for end of life care.
Complaints were responded to in a timely way and outcomes agreed.

The provider showed a commitment to reviewing and maintaining a quality service. There were systems in place to monitor people's care and evidence of improvements being made. Incidents were tracked and learning outcomes were identified. The manager ensured statutory notifications were sent as required. People living at the home also benefitted from the relationships the service had formed with local organisations.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained safe.	Good
Is the service effective? The service remained effective	Good
Is the service caring? The service remained caring	Good
Is the service responsive? The service remained responsive	Good
Is the service well-led? The service remained well led	Good

White Gates Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced comprehensive inspection that took place on 3 December 2018.

The inspection was carried out by two inspectors, one specialist nurse advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone living with dementia or who uses this type of care service.

Before the inspection we reviewed records held by CQC which included notifications and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. We also reviewed the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the inspection we spoke with 16 people and five relatives. We also observed the care that people received and how staff interacted with people. We spoke with nine staff during the day, including the registered manager and a regional manager. We reviewed care plans of 11 different people and the records relating to any accidents and incidents. We observed people's medicines being given. We looked at mental capacity assessments and any applications made to deprive people of their liberty.
We looked at four staff recruitment files and evidence that all staff had up to date training and supervision.

We checked whether mandatory policies and procedures were in place and the documentation that showed whether regular monitoring of equipment and the premises was being done. We reviewed internal audits and responses to complaints to understand how well the service was being governed and managed.

We received feedback from two health and social care professionals.

Good

Is the service safe?

Our findings

People told us they felt safe living at White Gates. One person said, "The staff really care, that makes you feel safe. You hear so many things about homes but here we are safe and they look after you." One person's relative said, "She is very safe, I don't worry."

People were helped to stay because staff understood their role to safeguard people from harm or abuse. Staff had received safeguarding training and the registered manager ensured that any incidents and concerns could be discussed openly. One staff member said, "I would report to my manager any concerns about the safety of people in our care." After a concern about missing money, for example, the appropriate action had been taken to safeguard the person and the right agencies were informed.

The risks people experienced due to their specific needs had been assessed in order to keep them safe. The actions for staff to take to reduce the risk were recorded. For example, a person who was registered as blind needed help to stay safe when mobilising. The care plan gave guidance for staff to remind the person to keep their head up when walking to maximise their vision and their balance. We saw that staff did this. A person's diabetes care plan included regular foot care, as well as details about diet and blood glucose monitoring, signs to look out for and actions to take in the event of an emergency. There were hourly checks in place to minimise the risks for those people who were cared for in their rooms. This showed when people were repositioned and that their intake of food and fluids was monitored. People as risk of falling from bed due to their needs has been assessed for having bed rails, and we saw that these were in place.

People's individual support needs in the event of an emergency or fire had been identified and recorded. It was evident that regular safety evacuations were carried out and staff could describe what to do in the event of a fire to support people.

There were sufficient staff to safely meet people's needs. At the time of inspection there were eight care staff and two nurses on the rota at the time of inspection as well as the activities co-ordinator and housekeeper. This was meeting the required levels based on the homes dependency tool and people's needs were met. However, some people and relatives reported having to wait for staff to attend to them in the evening or weekends. From the most recent staff rotas we found two occasions, on Sundays, where there was one less staff member on duty. The service was also carrying some vacant hours for housekeeping and activities. One staff member said, "It has a knock-on effect. If we have eight care staff, and the kitchen and housekeeping staff then it's fine." The registered manager told us about times when staffing levels had dropped due to unexpected sickness, but they always tried to arrange cover at late notice. The provider had also introduced 'walkie talkies' for staff to communicate with each other, due to the layout of the home, and prevent any delays in response to people.

We recommend a staff contingency and on call system is put in place to ensure sickness is covered and the right levels of staff are always in place.

Staff had been safely recruited. Prior to employment the provider obtained details of the applicant's

previous work history, two references and a check with the Disclosure & Barring Service (DBS) was completed. The DBS keeps a record of potential staff who would not be appropriate to work in health and social care. The nurses were also registered with their professional body; the Nursing and Midwifery Council.

People's medicines were stored and administered safely by trained nurses. People's medicines administration records (MARs) were clearly legible. Each record had the person's photograph and any known allergies were listed on the front. There were no missed signatures on the sample of records we checked. Two nurses always checked and signed for new stock and all medicines were clearly labelled. The bottled medicines had the opening date written on them. Any 'as required' (PRN) medicine was not being used excessively and there were individual plans in place for the use of these. All medicines were locked away appropriately in the clinic room and specialist drugs for end of life care where stored in a separate locked cupboard. The room and refrigeration temperature was monitored and recorded daily. On the day of inspection, the temperature was noted as being high and corrective action was taken immediately.

People were protected against the risk of the spread of infections. Staff were aware of good practice and cleanliness and hygiene was evident in the home. Staff had access to, and used, the correct personal protective equipment. One staff member told us, "I wash my hands before going in to someone and again when coming out. I wash my hands before giving people food and I always encourage the residents to wash their hands to help stop the spread of infection."

People were kept safe following any accidents or incidents and lessons were learnt by staff. All incidents and injuries were logged and the outcomes and actions were recorded. For example, a missed signature on a medicines record was noticed. GP advice had been sought and the person's family had been notified. The nurse responsible was reminded of the correct practice and observed on their next shift. A person had been given a pendant alarm to wear after a fall and concerns that they could not use the call bell. Additional checks were in place after another person had left the building unattended. Learning was discussed with the staff to prevent future occurrences wherever possible.

Good

Is the service effective?

Our findings

People told us that the staff at home were knowledgeable and were skilled at their job. People's comments included, "The staff are all so good, that makes me feel so much better." And, "I think they are pretty good, they do a good job."

People were supported by staff who had received training and were supervised to deliver effective care and support. Staff acted with care, when giving people their medicines or when using a hoist and sling to transfer and move people. New staff had received face to face induction training including mandatory knowledge on safeguarding, infection control, and moving and positioning people. One new staff member told us, "It's good training. I am shadowing at the moment. They support me to learn."

Regular supervision was in place for all staff. The nurses were supported to achieve their professional revalidation and received their clinical supervision from the registered manager, who was also a registered nurse. The annual appraisal system was comprehensive, with an individual assessment of the core competencies for each role in the home. One nurse told us. "I can request additional training at my supervision or appraisal."

People's needs were assessed and care was delivered in line with current good practice guidance. Care plans provided insight and information into the individual's mental and physical health. There was an awareness of the need to keep up to date and deliver care in line with NHS and NICE guidance, for example for pressure sores, preventing infections and dementia awareness. Care planning and risk assessments were underpinned using recognised clinical tools to measure people's nutrition and skin integrity.

People benefitted from the way the staff worked together and with other services to ensure effective care and support. One staff member told us, "We work in our own areas and get to know people's needs well, but we can always ask the nurse in charge for advice." There were daily handover meetings held, between the night and day staff shifts and between nurses and care staff so that all the team were aware of any changes with people's needs. Referrals to other professionals was evident, for example to the GP for a medicine review or to the community mental health team where a person's mood or behaviour was a concern.

People were supported to live as healthily as possible and were helped to access healthcare services. We heard from people and relatives that there was good access to medical support. One person said, "I can see the doctor whenever I want and the staff help with that." Where a person had developed a pressure sore, prior to moving into the home, there were good treatment plans in place and there had been liaison with a specialist nurse about what this person needed. We heard from a relative who told us that, "Staff picked up that (name) had an infection straight away."

People were supported to eat and drink enough and had a balanced diet. People were assessed for risk of weight loss and malnutrition and if necessary their food intake was monitored. Any special dietary needs were being met. People told us they liked the food that was served. One person said, "We have very nice, good food, and I always see a choice." Another said "They come around and ask me what I would like, and

show me the choices." This included those who were on a soft or pureed diet. One person's care plan gave specific instructions about how they needed their food presented due to their visual impairment and we saw this was followed by staff to encourage them to eat.

The home was suitable to meet the needs of the people who lived there. Some adaptations were made to support people to be as independent as possible. For example, there were three-wheeled mobility trollies being used by some people and adapted baths and ceiling hoists were in place where required. The toilet doors were clearly signposted to help people with dementia or poor sight. However, some people with dementia would need assistance to find their way around the home as much of the décor was neutral and their bedroom doors did not stand out.

People who lack the mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were not being restricted without legal authorisation and consent was sought by staff before providing care and support. One person said, "They always explain what they are doing first." The staff had correctly assessed people's mental capacity before putting in place any restrictions in their best interests. For example, some people were given medicines covertly and some had bed rails in place that could not be consented to. One person was still offered their medicines first, as this was the least restrictive option and their mental capacity to agree was variable. The home had applied for MCA authorisations for some people who could not consent to living there and there was evidence that the decision was made in consultation with their families and in people's best interests.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and respect. One person said, "Yes they are always careful and I do feel respected." Another said, "They always show respect and are kind." A third person said, "Care is good, staff are good."

People were supported in a kind and compassionate way. Staff knew people individually and engaged with them positively. A nurse giving a person their medicines spoke to them gently, "Are you ready to take your pain killer now." They gave the person and their relative lots of reassurance, and explained what they were doing and why. We saw staff talking with people as they came into the lounge. One of the staff told a person, "You smell nice today," which made the person smile. Another staff member escorted a person in a wheelchair and then spent time asking and helping them decide where they would sit.

People and their relatives were involved in the care and able to express their views. The care plans included discussions with people and families about their care needs. One person's relative visited daily with their dog and said, "I am made to feel welcome. If for any reason I cannot make it for a day I never worry about (name) while she is here. I have been fully involved in her care." Another relative told us that when they were worried about their loved one, they had, "Chatted to the staff and they were very helpful." The reception is brilliant you can ask anything, nothing is too much trouble."

Staff told us how they supported people who could not verbalise to communicate their choices. One care worker said, "We try to show people what is on offer. People are helped to choose and may also change their mind. Some people 'talk' with their expressions."

People's independence and choice was promoted. For example, a person who was at risk of falls was wearing a pendant alarm and reminded to ask for help when mobilising. This enabled the person to have some freedom but stay as safe as possible. At meal time, some people were given adapted cutlery or a special plate, which enabled them to eat independently. One person told us, "I can please myself and can do what I like. They encourage you to do what you like."

People's dignity and privacy was respected. Some people had chosen to stay in bed or in their room that day. Their meal was taken to them and we were told they valued their privacy. One staff member told us, "This is their home and we should treat it as such. We only want the best for them and we should give them the respect they deserve." One person told us, "This is an open, very homely place, when I walked in here my mind cleared, I did not have to worry anymore."

Good

Is the service responsive?

Our findings

People's care was personalised to them and to meet their individual needs and choices. Care plans gave personal information that enabled staff to get to know each person well. For example, we read that one person, who was visually impaired, liked listening to their radio and to the sport. We saw that the person had their radio and earphones brought to them in the lounge. Another person had developed low moods and expressed unhappiness about the home. There was good evidence in the care plan that staff had responded and were understanding. They had enabled the person to speak to their GP in private and to get support. The person wanted to stay in their own room and staff knew to ensure they had their call bell and newspaper to hand, and to engage with the person whenever they were willing.

People's care was reviewed each month, or as their needs changed. Each person and their family or representative was involved in this. People confirmed they had been asked and included in agreeing and reviewing their care. One person said, "They ask me what I think and they write it down, they do ask me, yes."

People had access to group activities within the home, based on what people enjoyed. One person told us, "There's so much going on, look today they have animals and we have music and singing. Everyday something is on for us." People could choose what they took part in and some people told us they did not want to join in. The activities co-ordinator was aware of this and said, "I always ask people prior to starting an activity. It is not imposed on anyone." At the time of the inspection, there were vacant hours for activities staff which meant it was harder to ensure people had one to one time if they stayed in their room. Recruitment was taking place.

The registered manager told us that some people had, "Freedom to come and go out as they wished." Most people needed support to go outside of the home. The activities coordinator told us that lunches in town as well as Christmas shopping and theatre events had been arranged for people. They said, "Everyone who can go out, goes."

People told us they knew how to feedback any concerns they had. A complaints process was in place. One person said, "I go and see the manager anytime, no problems if I have to raise anything." There had been nine complaints in the last year, three of which related to staffing and lapses in care. Each had been thoroughly considered and responded to with an apology. There were learning outcomes and actions, such as call bell audits and night checks to be put in place for one person.

People were supported at end of life by staff who were knowledgeable and were aware of national best practice guidance. The service had been accredited and implemented a national standard (Gold Standard Framework) for end of life care. This meant that people were identified in a timely way if they needed additional care or medicines. The staff worked with the hospice, GP and community nurses to ensure people could remain in their preferred place of care and get all the support they needed to do so. It also allowed people to be discharged from hospital to die in the home if this was their choice. Care plans were being updated to include people's wishes for end of life as some still had limited information. There was no one

receiving active end of life care are the time of inspection. The lead nurse, who was trained and had shared knowledge with other staff, said, "All the team knows GSF so the person can get the right care. We have a proactive approach to end of life."

Good

Is the service well-led?

Our findings

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider instilled a culture compassionate and competent care. The registered manager said that they wanted people to, "Live their life in the way they want."

People and staff said the service seemed to run well. For example, one person said, "The manager is friendly, and asks me how everything is going. Yes, I would go and see her if I needed to." One staff member said, "I feel supported. We work well together as a team. The management do not let us down." However, some people told us they did not know the registered manager well. One person told us. "The manager is always in the office not really around much." The registered manager said they were still developing their role as a manager having previously worked as a staff member in the home. They said, "I want to be more visible and am working, listening to people, relatives and staff. The regional manager confirmed that they had seen improvements with the registered manager's communication skills.

The home had a clinical governance framework in place that ensured risks and service standards were reviewed. This demonstrated that care plan reviews, accidents, complaints, and clinical events such as infections and pressure sores were being tracked. These were reported monthly within the provider organisation as well as any staffing issues and supervisions undertaken. The registered manager had informed the CQC of significant events, incidents and safeguarding concerns in line with legal requirements. There were monthly managers meetings in place. The registered manager attended and told us, "We learn from others and examples of any incidents or safeguarding as well as sharing good practice on person centred activities." A recent workshop on recruitment and retention of care staff was recently held.

Quality assurance checks and audits were in place. There was a business continuity plan in place. Health and safety and environment checks included the fire alarm system, fire doors, electrical testing, emergency lighting and water temperature checks.

People's care was monitored including their nutrition and weight, night care spot checks and call bell response times. Waiting times for people were now being checked and we saw a note to senior staff that call bells would be "audited twice a day for seven days to ensure call bells get answered in four minutes." The recent audit showed there were some five-minute response times and one that was eight minutes, but the majority were within the four-minute target. This showed that the service was responding to people's feedback and a complaint about an unacceptable wait for one person.

People had an opportunity to have a say in the way the service was delivered. People's views were sought individually through the 'resident of the day' process, where a review of the everything that affected the person's care and experience was checked with them and their family. There were also bi-monthly meetings

held for people and their relatives. At the last meeting a trip to the pantomime from Christmas was agreed and new meal suggestions were discussed. A staff member said, "We want to make life interesting for people, and hear what their ideas are."

Regular staff meetings were held to support good communication amongst the team and amongst staff groups. The nurses had their own meeting and activities were also discussed separately. The dates were well organised in advance. The registered manager said, "The staff team has changed and developed. I ask them how would they make the day go better for people. We try new things, things change and we all need to keep up."

The service had developed relationships with community services for the benefit of people. A local healthcare professional told us, "I have a good working relationship with the nursing team which makes my visits effortless and enjoyable. I currently have no concerns." Staff attended training in dementia care organised by the local care home forum. The service had also introduced an agreed plan for identification of sepsis. The relationship with the local hospices was good and the service was known for their proactive standards with end of life care. The registered manager was a member of the Surrey Care Home Association and told us how they, "Shared experiences with other managers, and this really helps us to get other ideas."